Scaling Up Towards Universal Access to HIV/AIDS Prevention, Care, and Treatment

DRAFT

Timor-Leste Country Report

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMI	Assistencia Medica Internacional
ARV	Anti Retro Viral
ASHM	Australasian Society for HIV Medicine
CBO	Community Based Organization
CCF	Christian Children's Fund
CCYCF	Comoro Child and Youth Foundation
CRS	Catholic Relief Service
CVTL	Cruz Vermelha Timor Leste
CWS	Church World Service
DCI	Development Cooperation Ireland
DENORE	Development of Knowledge and Research
FHI	Family Health International
FSW	Female Sex Worker
FTH	Fundassaun Timor Hari'i
HAI	Health Alliance International
HIV	Human Immune Deficiency Virus
IOM	International Organization for Migration
MARG	Most At Risk Group
MOE	Ministry of Education
MOH	Ministry of Health
MSM	Men who have Sex with Men
NAPWA	National Association of People Living with HIV/AIDS
NGO	Non Government Organization
PWHA	Person With HIV/AIDS
STI	Sexually Transmitted Infection
UNAIDS	United Nations AIDS program
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

1.0 BACKGROUND

Timor Leste is a country in the early stages of national development. As such it faces significant challenges common to all new nations as well as specific challenges resulting from its own unique history, culture and environment.

It is believed that HIV prevalence in Timor Leste is currently low. However HIV/AIDS has had a devastating impact on other countries in comparable circumstances to Timor Leste. Among Timor Leste's nearest neighbors Papua New Guinea appears to be in the early stages of a generalized HIV epidemic which threatens to not only halt, but reverse the development achievements that nation has made in its relatively short history. Many of the circumstances that have led to the current HIV situation in Papua New Guinea are also present in Timor Leste including large scale social dislocation and high levels of HIV related risk behaviors.

Timor Leste has adopted a National Development Plan[1] that provides clear strategic directions including processes for implementation, to address development challenges. The government, key organisations within civil society and international development partners, has also recognized the unique challenge HIV/AIDS creates to sustaining strategies required to develop this new nation.

Over the past four years Timor Leste has adopted and implemented strategies, policies, programs and projects to address HIV/AIDS. However among key stakeholders it is generally accepted that while many effective activities have been implemented overall coordination is weak and important gaps exist.

During 2005 the Government through the Ministry of Health in partnership with civil society organizations and United Nations agencies engaged in a consultative process to develop a new national strategy to provide a more comprehensive and coordinated response to HIV/AIDS and STIs. That process also entailed identification of obstacles to scaling up the response to HIV across prevention, treatment, care and support and strategies to address those obstacles. Total attendance at workshops conducted with all districts, cross sector workshops and two national conferences was over 700.

Based on the consultation process and other sources of information this report covers the following matters:
- current need and program coverage related to prevention, treatment and support
- obstacles and proposed solutions regarding advocacy and political commitment, sustainable financing, harmonization and programming, human resources, health systems and infrastructure, human rights, gender, equity and enabling environment commodities, services and partnerships
- discussion of targets and milestone

[1] Planning Commission, East Timor *National Development Plan*, Dili May 2002.

2.0 CURRENT SITUATION

2.1 Prevention - Risk and Vulnerability

There are significant gaps in strategic information necessary to make a definitive assessment of current levels knowledge, attitudes and behaviors relevant to HIV prevention. (these gaps are addressed in the new national strategic plan). However various sources of information do suggest within the broader population knowledge of HIV is low, it is not perceived as a significant risk and that unprotected sex with multiple partners is not uncommon.

More generally there are factors related to social vulnerability that create obstacles to prevention and/or heighten risk associated with behaviors that lead to HIV infection. These include high levels of poverty, low literacy levels, and high rates of social mobility.

In late 2003 a quantitative study of risk factors among groups identified in Timor-Leste as most at risk (Female sex workers, men who have sex with men, members of the uniformed services, taxi drivers) was conducted[2]. Among each group condom use and knowledge regarding HIV was low. Among female sex workers and men who have sex with men rates of STIs was high.

Anecdotally it is reported that injecting drug use is relatively infrequent in Timor-Leste. However the extent to which this behavior may occur has not been adequately investigated. Moreover various factors suggest injecting drug use may become a more widespread phenomenon in future years as Timor-Leste becomes more exposed internationally. They include:
- Timor-Leste borders Indonesia where injecting drug use is fuelling more widespread HIV transmission.
- Significant numbers of people from Timor-Leste are going overseas for employment
- Tourism has been identified as a priority industry for development in the National Development Plan and will result in more outsiders entering Timor-Leste

Currently HIV testing rates and more broadly, utilization of VCT services are low.

Routine surveillance of STIs is underdeveloped and unlikely to provide a meaningful indication of infection rates. However between January and October 2005, 1259 STIs were reported to the Ministry of Health[3]. The transitory nature of STI symptoms, low population awareness of STIs, documented practices of self treatment, stigma and minimal diagnosis of asymptomatic infection, suggest the number of infections reported is likely to be a small percentage of actual infections. High levels of STIs are an indicator of HIV risk because of common routes of transmission, while also increasing the biological risk of HIV transmission.

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[2] Family Health International, *HIV, STIs and risk behaviour in East Timor: an historic opportunity for effective action,* Family health International, Dili 2004.

[3] Ministerio da Saude, Republica Democratica da Timor Leste. *Bulletin Epidemiologia.* Department of CDC. MOH Dili October 2005

Among female sex workers in the 2003 FHI study 14% tested positive for gonorrhoea, 15% positive for chlamydia, 16% positive for trichomonas and 60% for HSV-2. At the same time among a sample of MSM 14% tested positive for gonorrhoea, 13% positive for chlamydia, and 29% for HSV-2.

Rates of gonorrhoea and chlamydia among taxi drivers and soldiers in the 2003 FHI study were relatively low. Among taxi drivers 1% tested positive for gonorrhoea and 2% for chlamydia. Among soldiers 0.5 % tested positive for gonorrhoea and 2% for chlamydia. However given that sex workers are the main extra marital sexual partners of these populations and that more then 50% have extramarital partners these rates could have increased significantly since then.

Current Program Coverage (Prevention, VCT and STIs)

In recent years there have been intensive HIV prevention related interventions among some population groups. The Ministry of Education in cooperation with UNICEF supports provision of HIV/AIDS prevention and life skills based education aimed at reducing young people's vulnerability to HIV infection. UNICEF has produced modules for teaching life skills to young people at the junior secondary, senior level and those out of school. Trainers have been trained and the project has commenced initially in 6 districts (Dili, Baucau, Maliana, Manatuto, Lospalos, and Same) with plans to extend to all districts. The primary school curriculum will cover basic health and social skills. The secondary and out of school modules cover communication, relationship, decision making and problem solving skills, self awareness, coping with emotions, and STIs and HIV/AIDS[4].

A review of the national strategic plan covering the period 2002-2005 reported on a number of interventions as discussed below.[5]

Fundassuan Timor Hari (A Timor-Leste NGO) conducts youth programs in Dili, Suai, Maliana and Oecussi. Peer education is conducted in twelve schools in Dili. In cooperation with Oxfam a youth centre is run in Covalima.

Oxfam are also intending to open a youth centre in Oecussi.

Cruz Vermelha Timor-Leste CVTL (a Timor-Leste NGO linked to the Red Cross)conducts outreach to secondary and university students. In addition young people aged 15-25 are trained as peer educators. Youth centres are being developed in Dili and Baucau.

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[4] Ministry of Health. *Expanded comprehensive response to HIV and AIDS in Timor Leste.* Submission to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Ministry of Health, Dili June 2005

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[5] Fowler D, *Review of the National Strategic Plan for a comprehensive and multisectoral to HIV/AIDS/STIs in Timor Leste 2002-2005*. Dili November 2005

Between 2001 and 2004 Deo Gratias conducted high school youth awareness projects targeting 14-18 year olds. The projects were conducted in Baucau, Manatuto, Dili, Liquica, Ermera, and Bobonaro.

Other organisations conducting activities targeting youth (usually in schools) include Denore, Plan International, CCF, Esperanca Loro Sae, CCYCF, and UNOTIL.

Fundassuan Timor Hari'i (FTH) and Cruz Vermelha Timor Leste (CVTL) cooperate closely in conducting outreach based prevention programs for female sex workers. Activity is mainly in Dili but also occurs in other districts. It is estimated that contact has been established with approximately 350 FSWs in Dili, Bobonaro and Covalima.

Fundassuan Timor Hari'i projects have reached 1300 clients of FSWs in Dili, Bobonaro and Covalima.

FTH have implemented a mapping project for Oxfam in Suai. The project estimated that there are approximately 70 female sex workers in Suai. Funding has now been provided to a Suai based NGO to conduct outreach there.

Other organisations which have worked with FSWs include ETWAVE, Denore, Alola and Pastoral da AIDS.

Fundassuan Timor Hari conducts prevention programs targeting men who have sex with men. In Dili programs reach approximately 500 MSM which is believed to be most of the open MSM in the city. Fundassuan Timor Hari also operates a drop in centre for MSM in Dili where information and free condoms/lubricants are provided. CVTL assists.

Fundassuan Timor Hari provides targeted education to military and police nationwide. In Dili additional activity includes high level advocacy among leaders, training trainers and peer education projects.

A number of organisations have been involved in developing capacity in VCT. However anecdotally several critical informants suggest that good practice only occurs at a small number of clinics.

. Extensive training has been provided in STI syndromic management. However although staff at 37 sites have received training an evaluation study showed that no site met expected criteria. Although knowledge on syndromic management was satisfactory, only 23% of the facilities evaluated used the standard protocol.[6]

2.2 Treatment (Need and program coverage)

The number of cumulative diagnosis of HIV reported in Timor-Leste is 33. However the actual number of infections is likely to be much higher. HIV testing rates even

among most at risk groups is low. There are few VCT services. Most HIV diagnoses occur when a patient presents with symptoms of advanced illness.

It is believed that around 14 people are currently receiving anti-retroviral treatment in Timor Leste. The Brazilian Government has committed to providing sufficient anti-retroviral drugs for many times this number of patients. Training and technical assistance related to the provision of HIV treatment is also being provided particularly by WHO, ASHM and the Brazilian Government.

While certain key components necessary for ensuring universal access to treatment are in place (i.e. availability of drugs, sufficient clinicians trained in HIV management) various systemic obstacles need to be addressed in scaling up. These are discussed in section three of this report.

2.3 Care and Support (Need and program coverage)

Currently counseling services are available for most people living with HIV. However current capacity will be insufficient should there be a significant increase in diagnoses as expected (due to current undiagnosed infections and possible increases in transmission).

A small number of NGOs as well as a semi private clinic are working with HIV positive people to establish a peer support group.

3.0 OBSTACLES AND PROPOSED SOLUTIONS

The UNAIDS Regional Support Team for Asia and the Pacific is seeking input regarding obstacles and proposed solutions in the following areas:

- advocacy and political commitment
- sustainable financing, harmonization and programming
- human resources, health systems and infrastructure
- human rights, gender, equity and enabling environment
-commodities, services and partnerships

3.1 Advocacy and political commitment

Obstacles

There has been high level political commitment to HIV/AIDS in Timor-Leste as evidenced by the adoption of a national strategy in 2002 just after independence when many urgent priorities faced the nation and more recently in the process to develop a new strategic plan which was led by the Minister of Health. However the following obstacles have adversely affected sustaining commitment and ongoing advocacy.

- limited involvement in policy formulation and strategy implementation by sectors other then health;
- dysfunctional national advisory structures
- limited engagement of districts outside Dili the capital
- lack of broad understanding of the potential threat HIV poses to the national development of Timor-Leste

Proposed Solutions

The new national strategic plan proposes strategies to address these obstacles over the period 2006-2010.

The strategy proposes the establishment of a National HIV/AIDS Commission (NAC) as the key advisory structure at the national level. Its membership would be both multi-sectoral and expert based. Sub committees and expert working groups drawing upon a broader membership base would be auspiced by the NAC to develop advice on specific policies, guidelines and protocols required for program implementation

The proposed role of the NAC is advisory as opposed to program coordination and implementation. Inputs to that advice will be drawn from the range of agencies involved in the response to HIV/AIDS/STIs in Timor Leste. It is neither practical nor desirable (given limited resources) to replicate that expertise within the organisational infrastructure of the NAC. However a secretariat function will be provided to meet administrative requirements (office space/equipment, project management, secretarial support).

It has been proposed that the Minister of Health chair the National AIDS Commission. While HIV requires a multi-sectoral response, lead government responsibility is located within the Ministry of Health. Having the Minister as chair will provide a voice within broader government structures (e.g. the Council of Ministers) and encourage high level representation from other sectors.

To broaden the response to HIV nationally the strategy proposes the development of district plans and local coordination structures. In developing the new strategic plan consultation occurred with all districts and draft district plans have been developed. Almost all districts have indicated their interest in developing an ongoing forum with cross sector membership to assist in coordination of district plans and advocate around HIV policy issues.

It is also proposed in the strategy to conduct social marketing campaigns to reach the broader population. While key messages would focus on increasing knowledge of personal risk and risk reduction behavior they would be contextualized so as to increase understanding of the broader threat to the nation's development and create an enabling environment for implementing necessary interventions.

Youth targeted campaigns are also proposed. To ensure maximum reach as well as to build broader ownership, support and involvement will be sought across sectors.

Strategic Information is one of the organizational components of the new national strategy. Such information will include a more detailed and objective assessment of social factors that contribute to vulnerability. This will provide a more informed and compelling basis on which to build commitment to HIV strategy.

3.2 Sustainable financing, harmonization and programming

Obstacles

The level of funding that has been available for HIV is insufficient to meet the strategic objectives outlined in the new national strategy. Availability of funds is largely dependent on donors. A major donor USAID intends to cease funding of HIV programs by mid 2006 which in the absence of alternative funds will result in the cessation of prevention programs targeting most at risk groups.

The lack of a program focused strategic plan has meant that priorities for HIV funding have been largely determined by donors. While some projects which have been funded are in accord with the priorities of the newly developed strategic plan, the overall programmatic response has been patchy and uncoordinated. In some cases there has been extensive duplication of effort (e.g. VCT training), no strategic assessment of need, and no clarity regarding ongoing programming.

There has been no functional coordinating body for the various program funders and implementers to reach agreement on harmonization of programming efforts.
Proposed Solutions

The Global Fund to Fight AIDS, TB and Malaria has provisionally agreed to allocate $9.4 million over the next five years to fund HIV programs in Timor-Leste. A five year costing of the new national strategic plan has been conducted and it is largely consistent with the Global Fund proposal. The adoption of one national strategy, the establishment of the National AIDS Commission, and the development of one monitoring and evaluation framework (the three ones) will provide a framework for harmonizing the funding of the national strategy.

The proposed National AIDS Commission will have four standing committees which cover the four program components of the national strategy (i.e. Prevention and education, VCT, multi-sectoral action and clinical services). Attached to the strategy is a five year implementation plan and one year business plan which will be used to guide the work of the standing committees.

3.3 Human resources, health systems and infrastructure

Obstacles

Across the organizational sectors (i.e. government, non government, international and private) there is a strong base in regard to human resources to scale up the strategic response to HIV/AIDS. However there are gaps in technical capacity necessary for the development of policies, protocols and procedures on some matters, and training will need to be provided to establish operational capacity in some areas of program implementation. Furthermore capacity development will need to occur in those sectors outside health from which involvement is being sought.

The provision of HIV treatment in Timor Leste presents unique challenges to the health system. It requires the provision of highly specialised services in a resource poor setting where the priority in health service provision is to ensure access to basic primary health care services. However it also involves the provision of testing services through those basic primary health care services with appropriate referral mechanisms where infection is diagnosed. Efficient linkages are also required between different functional areas (treatment, laboratory services, and pharmaceutical provision).

There are obstacles to universal access in regard to delivery of HIV and STI diagnostic and treatment services, management of pharmaceuticals, laboratory services, blood supply and infection control.

Proposed Solutions

HIV Treatment Services

It is feasible in Timor Leste to ensure the availability of HIV antiretroviral treatment to all those diagnosed with infection. Numbers believed to be infected are relatively low. Antiretroviral drugs are available from donor nations. Technical support for the development of system and human resource capacity is available from international agencies. Additional funding is available through the Global Fund for other

infrastructure needs. The basic infrastructure for the delivery of services exists in Timor Leste.

Given the relatively low number of people believed to be currently infected with HIV and the complexity of treatment, delivery of antiretroviral treatment should be focused at a small number of sites. Where patients are located outside of Dili partnership arrangements should be made with local health services for drug storage and ongoing patient monitoring on the basis of non laboratory diagnostic procedures (e.g. weight loss, symptoms of opportunistic infections) with regular periodic referral to specialist facilities for full assessment.

The National Hospital in Dili in addition to being a site for antiretroviral delivery should also provide HIV inpatient facilities as well as being the HIV prescribing site for patients outside of Dili. If over the next five years the number of patients increases significantly outside of Dili the provision of antiretroviral prescribing should be expanded while more specialised inpatient facilities remain centralised in Dili.

Policies, protocols and procedures need to be developed across all aspects of patient management. An immediate priority is the development of guidelines regarding when to commence and alter antiretroviral treatment based on clinical assessment and international best practice while also taking account of factors specific to Timor Leste (e.g. drug storage capacity outside Dili, transport of specimens for laboratory diagnostic testing) and the drugs available through donation from Brazil. While allowing for flexibility in the implementation of patient management guidelines based on clinical assessment by individual clinicians, protocols regarding patient review should be developed for quality assurance purposes.

Procedures covering patient confidentiality need to be developed. The issues to be covered, range from exchange of information between clinicians and health care workers, to the availability of patient records.

Human resource development needs range from those required by highly specialised clinical staff to auxiliary staff (e.g. among cleaners addressing fear of infection, respect for confidentiality). For more highly specialised clinical training Timor Leste is currently dependent on external providers. For financial reasons (i.e. the cost of such training is expensive but generally provided free by external organisations) and capacity, this is likely to continue over the life of this strategy. Harmonisation between training provided by external organisations should be promoted to ensure consistency in treatment service provision through compliance with patient management frameworks developed in Timor Leste.

Relationships with other areas of clinical service provision need to be developed. Priorities are other infectious diseases – particularly TB because it may be an indicator of HIV infection and clinical management of co-infection – and reproductive health (to ensure integration of prevention of mother to child transmission). Shared care protocols need to be developed and ongoing relationships maintained.

Developing an appropriate policy framework for HIV clinical service delivery, getting commitment to its implementation and building clinical policy capacity in Timor Leste requires participation from clinicians. The establishment of a standing committee on clinical services under the National AIDS Commission would provide a mechanism for achieving this.

STI Treatment Services

STI treatment in Timor Leste occurs within the framework of either syndromic management or enhanced syndromic management.

Syndromic management is diagnosis of infection on the basis of symptoms, provision of counselling, and provision of treatment, according to standard protocols. Timor Leste has adopted a policy framework (Basic Package of Services)[7] for the delivery of services. The basic package of services states that STI counselling and treatment should be provided at all levels of health service delivery in Timor Leste[8].

National guidelines on STI syndromic management were developed, and training was subsequently provided in 2001 and 2002. More then 270 health personnel (including170 midwives, 57 nurses and 23 doctors) were trained. However a survey in 2004 showed that only 23% of facilities complied with standard protocols and that there was a shortage of STI drugs in most facilities[9].

A review of syndromic management to identify the reasons for poor compliance needs to occur. The review also needs to assess current capacity to provide syndromic management at all health services. On the basis of that review protocols may need to be revised and additional training provided.

Enhanced syndromic management is diagnosis on the basis of laboratory testing, pre and post test counselling (including sexual history taking) and treatment. There are no existing Ministry policy frameworks covering enhanced syndromic management. A small number of sites in Dili provide laboratory based diagnosis of STIs within variable frameworks of enhanced syndromic management. Protocols may be site based, research project based or non existent.

Enhanced syndromic management should be the standard of STI management for most at risk groups. STIs are often asymptomatic and most at risk groups because of higher rates of sexual partner change are more likely to be both at risk of, and transmit STIs. Integration of counselling in STI management can also contribute to the adoption of safer sex practices.

Protocols need to be developed for enhanced syndromic management of STIs for MARGs. In addition capacity needs to be established to provide enhanced syndromic

[7] Ministry of Health, Timor Leste. *Basic Package of Services Policy (Draft).* Dili, March 2004.
[8] Ibid. p30
[9] Ministry of Health. *Expanded comprehensive response to HIV and AIDS in Timor Leste.* Submission to the Global Fund to Fight AIDS, Tuberculosis and Malaria. Ministry of Health, Dili June 2005

management at a limited number of sites outside Dili where there are significant populations of MARGs. Access to these services needs to be promoted to MARGs.

Laboratory Services

Laboratory services are a key component of HIV service delivery. The Timor Leste Health Policy Framework identifies the National Laboratory attached to the national Hospital in Dili as being the central referral point for all laboratory services[10]. Laboratories with limited functions to mainly support diagnosis of malaria and TB are located in each of the districts. A number of unregulated private laboratories also exist.

Overall infrastructure capacity at the national laboratory is inadequate in regard to space, equipment and human resource skills. However many of these gaps are being addressed through assistance from a major international donor.

Laboratory capacity for the diagnosis of bacterial STIs and antimicrobial susceptibility is currently highly inadequate. Because of the higher susceptibility to HIV infection caused by bacterial STIs (recognised above in the higher priority proposed for enhanced syndromic STI management among MARGs) it is essential that this be redressed.

Surveillance of HIV and STIs requires laboratory based reporting systems. A regulatory framework is required that proscribes such reporting from private laboratories through licensing arrangements. Such a framework is also required to ensure quality in both the private and public sectors. Further quality mechanisms need to be established to ensure basic management functions are adequately implemented such as inventory control and procurement of requirements.

Procurement and supply of drugs and other commodities

Clinical management of HIV and a number of other strategic functions is dependent on an infrastructure that ensures reliable procurement, storage and distribution of essential drugs and other commodities (e.g. condoms, reagents for HIV testing). It is a priority that management in this area be improved. Comprehensive protocols and procedures need to be developed, management systems improved and human resource capacity enhanced.

Unregulated involvement by the private sector creates significant risk regarding the provision of substandard products and unethical (dishonest/misleading) marketing. A regulatory framework needs to be established to govern private sector involvement in this area.

Blood Safety

[10] East Timor Ministry of Health, *East Timor Health Policy Framework* ,Ministry of Health June 2002 p45

Minimising HIV transmission through blood transfusions requires adequate screening of the blood supply. Currently in Timor Leste infrastructure is inadequate to facilitate a level of blood donations required to meet needs. Consequently the system is heavily dependent on blood donations from families of patients. This involves risk of accidental residual transmission of HIV due to the window period of donation. Increasing voluntary blood donations can reduce this risk.

Accidental needlestick injury in health care settings is a risk for HIV transmission as well as other infectious diseases. The adoption of universal infection control procedures will minimise this risk. Protocols as well as quality assurance mechanisms need to be developed and implemented, and training provided to all staff working in health care settings.

The provision of post exposure prophylaxis (PEP) where needlestick injuries occur can reduce the likelihood of HIV infection. The availability of PEP can also increase the comfort of health care workers who are in contact with HIV positive patients thereby enhancing quality of care. Resource constraints limit the capacity to provide PEP to sites where HIV positive patients receive treatment. Protocols and training need to be developed for the provision of PEP.

3.4 Human rights, gender, equity and enabling environment

Obstacles

Issues of stigma and discrimination pose the greatest threat to human rights in relation to HIV. As a sexually transmitted disease many of the taboos anecdotally reported to be associated with discussion of sex in Timor-Leste may create an obstacle to promoting greater understanding of HIV – a necessary precondition to addressing stigma and discrimination.

Anecdotally there are reports of discrimination against people with HIV. The unwillingness of people with HIV in Timor-Leste reflects a perception at least of discrimination. This perception itself is likely to be a barrier to people getting tested.

Women have been recognized internationally as being additionally vulnerable to HIV both biologically and socially. In Timor-Leste patterns of social vulnerability are likely to mirror those elsewhere. These patterns include economic dependence on men, lower literacy and cultural beliefs regarding power in gender relationships.

More specific evidence of gender issues relevant to HIV have been identified in Timor Leste. The Regional Women's Congress has raised concerns about HIV/AIDS in relation to sexual violence against women. Rape and gender based violence represent 50% of the criminal cases reported to the police. The vast majority of the East Timorese female sex workers entered sex work after experiencing trauma, and many adult women entered sex work to sustain their families after their husbands abandoned them[11].

[11] Trafficking in East Timor. A look into the Newest Nation's Sex Industry 2004. ALOLA Foundation. 2004

Illiteracy and poverty result in inequity and increase vulnerability to HIV risk. Illiteracy is a barrier to HIV education and poverty can reduce access to the means of prevention.e.g. purchase of condoms.

Proposed Solutions

The Government of Timor Leste has recognised the need for multi-sectoral action to address health issues in the "Intersectorial Action Framework for Well Being and Health"[12]. That policy describes the need for involvement in inter-sectoral forums at both the national and district levels as necessary to advocate for public policy. Such advocacy is also required to support the goal of this strategy.

The Intersectorial Action Framework identifies HIV/AIDS as an issue requiring an inter-sectoral approach. Apart from health it recognises social services, education, gender, law and human rights as being particularly relevant[13]. In identifying gender and human rights the policy elsewhere discusses the need to address gender inequality and discrimination against marginalised groups.

The National AIDS Commission will also provide a forum for multi-sectoral public policy advocacy. The engagement of other sectors will facilitate dialogue around changes that can alleviate some of the consequences for HIV vulnerability resulting from inequity (e.g. removal of taxes on condoms).

The National Strategy 2006-2010 recognises sexual and reproductive health promotion as a fundamental requirement for people to protect themselves from HIV infection. Programs to achieve this outcome will help reduce stigma and discrimination by correcting misinformation about HIV.

A range of measures are outlined in the new national strategy to address discrimination against positive people. In addition to specifically protecting the rights of PLWHA and those most vulnerable to HIV/AIDS, it is also necessary that appropriate and accessible legal remedies are available to them. This can be done by inserting relevant provisions in the respective constitutional and civil and criminal laws where such safeguards do not already exist.

3.5 Commodities, services and partnerships

Obstacles

Availability of condoms is a significant barrier to universal access to prevention. In a setting where a significant proportion of the population lives on very low incomes the cost of condoms is significant.

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[12] Republica Democratica De Timor Leste. *Intersectorial Action Framework for Well Being and Health (Draft)*. May 2005. Dili
[13] Ibid p8

Supply management of commodities has already been identified as an obstacle in scaling up capacity in the health system.

Limited capacity to provide laboratory based screening of STIs is an obstacle to HIV prevention among most at risk groups as well as reducing transmission of other STIs. STIs both increase the risk of HIV transmission as well as being an indicator of sexual risk practices. Rates of STIs are high among sex workers and men who have sex with men and consequently asymptomatic infection is also likely to be higher. Laboratory diagnosis can contribute to the following outcomes:
- reduction in risk of HIV transmission
- reduction in risk of STI transmission
- opportunity for HIV/STI risk counseling

The lack of a program focused strategy and forum for coordination has been an obstacle to effective partnerships.

Proposed Solutions

Availability of funds through Global Fund mechanisms, continued donation of condoms by UNFPA and public policy to reduce taxation on condoms can reduce financial barriers to condom use.

Measures to address supply management and availability of laboratory based screening are addressed in the clinical services component of the new national strategy.

Clinical management of HIV and a number of other strategic functions is dependent on an infrastructure that ensures reliable procurement, storage and distribution of essential drugs and other commodities (e.g. condoms, reagents for HIV testing). It is a priority that management in this area be improved. Comprehensive protocols and procedures need to be developed, management systems improved and human resource capacity enhanced.

Unregulated involvement by the private sector creates significant risk regarding the provision of substandard products and unethical (dishonest/misleading) marketing. A regulatory framework needs to be established to govern private sector involvement in this area.

The strategy proposes that enhanced syndromic management of STIs become the standard of care for STI management among most at risk groups.

The new national strategy includes an implementation plan which is program focused and recommends the establishment of the National AIDS Commission. Both measures will facilitate effective partnerships.

4.0 TARGETS AND MILESTONES

Currently strategic information necessary to set targets and milestones is insufficient. Quantitative data regarding knowledge, attitudes and behavior among target populations is either non existent or out of date and therefore establishing baseline indicators is not feasible. For example data is available regarding most at risk groups in Dili from a major survey conducted in late 2003. However in the period since major health promotion interventions have occurred with these groups and consequently that data may no longer provide an accurate picture.

Limited service delivery and utilization data is available. Its utility for setting baselines and targets is unclear. For example staff from a number of primary health care outlets have received training in syndromic management of STIs and surveillance reports the number of syndromic STIs diagnosed. However compliance with standard protocols is low, the extent to which different sites have capacity to deliver this service is unknown and the extent to which diagnosed syndromic STIs provide any real indication of incidence or prevalence of STIs is unknown.

Strategic information is an organizational component of the new national strategy. Immediate priorities include quantitative studies of knowledge, attitudes and behaviors across the broader population as well as among most at risk groups. The development of a sentinel surveillance system is also a short term priority as a mechanism to develop and monitor prevalence and incidence. Standardised performance indicators will be developed to better measure program and project implementation.

Universal access to treatment, care and support and prevention is a realistic goal with adequate funding in Timor-Leste. The National Strategy identifies the requirements to achieve this outcome. Determination of milestones is dependent on the implementation of strategic information systems outlined in the strategy.

4.1 Performance Indicators

The table below outlines preliminary performance indicators for which baseline measures and targets will be developed. The first year business plan for the strategy includes conducting a national general population risk survey and specific surveys among most at risk groups. This will provide the data necessary to establish baseline data regarding knowledge, attitudes and behaviour. The establishment of a sentinel surveillance system and improvements in existing routine surveillance systems will provide data necessary for developing baseline data regarding prevalence and incidence of disease. Development of standardized reporting formats (partly through incorporation into existing reporting systems) will provide baseline data for system performance.

The development of targets for indicators regarding operational/system performance (e.g. number of sites where VCT is available, compliance with standard operating

protocols) is relatively straightforward although implementation of monitoring systems will require significant effort in design and training.

Targets for knowledge, attitudes and behaviors are more complex. Analysis of quantitative research (e.g. population risk surveys) and more intensive qualitative research (e.g. investigation of cultural and social barriers) as well as more detailed assessment of the impact of vulnerability factors (e.g. social mobilization) is necessary to develop realistic targets. Also benchmarking performance against other countries with comparative barriers will assist in defining realistic targets. These issues are addressed in the strategic information component of the new national strategy.

Draft Indicators

Prevention and Education

Impact

Indicator	Information Sources
Incidence of HIV infection	Sentinel surveillance
Incidence of STIs	Sentinel surveillance
% of program target population group (general population, youth, MARGs) that practice safe sex	Population survey; Anonymous health clinic surveys; Condom sales; STI surveillance
% of program target population group with STI symptoms that seek treatment from health clinics	Population survey; Anonymous health clinic surveys;
% of program target population group that know how to prevent HIV	Population survey; Anonymous health clinic surveys;
% of program target population group that know how to use a condom	Population survey; Anonymous health clinic surveys
% of program target population group that consider HIV a serious personal risk if they don't practice safe sex	Population survey; Anonymous health clinic surveys
% of program target population group that consider HIV a significant threat to the development of Timor Leste	Population survey; Anonymous health clinic survey
% of program target population group that would not engage in discriminatory practices against People with HIV.	Population survey; Anonymous health clinic survey; Documentation of discriminatory practices
% of young people who are confident in their capacity to resist pressure to have sex when they choose not to	
Frequency of STI testing among MARGs	Sentinel surveillance
Awareness of asymptomatic STI/HIV infection among MARGs	MARG population surveys

Process

Indicator	Information Sources
The number of agencies/sites where print resources are available for clients	District reports
The number of agencies implementing education programs	District reports
The availability of information resources at suco/sub-district level	District reports
The implementation of a multi-sector public education program in each district	District reports
The level of accurate media coverage of HIV/STIs in Timor Leste	

% of schools implementing life skills education for young people	Implementing agency reports
Number of youth centres where life skills education is implemented	Implementing agency reports
Number of sites frequented by sex workers that outreach education is implemented	District reports
Implementation of specific projects for Military, police, clients of sex workers, itinerant workers.	NAC Information collection, District reports

VCT

IMPACT

Indicator	Information Sources
Frequency of STI testing among MARGs	MARG behavior surveys; Sentinel surveillance
% of MARGs ever tested for HIV	MARG behavior surveys; sentinel surveillance
% of MARGs tested for HIV after HIV risk exposure	MARG behavior surveys; sentinel surveillance
% of pregnant women tested for HIV	Health Management Information System
% of VCT clients with improved knowledge and skills to reduce risk of HIV/STI transmission	MARG behavioral surveys; Measurement of changes against benchmarks in quality improvement program
Reduction in risk behavior among VCT clients	MARG behavioral surveys; Sentinel surveillance
% of people diagnosed with HIV without an opportunistic illness	HIV surveillance system

PROCESS

Indicator	Information Sources
VCT services available at all public health services	Health Management Information System
VCT offered to all pregnant women	Health Management Information System
Standard protocol developed for provision of VCT to pregnant women	Protocol distributed by MOH
Standard protocols developed for provision of VCT to MARGs	Protocols distributed by MOH
Standard protocols for providing VCT to general population	Protocols distributed by MOH
Compliance with standard protocols	Quality Improvement System
MARG targeted VCT services available in all districts	Health Management Information System

CLINICAL SERVICES

IMPACT

Indicator	Information Sources
% of people with HIV surviving x years after diagnosis	Health Management Information System (HIV observational data base)
% of people with HIV experiencing opportunistic illness	Health Management Information System (HIV observational data base)
% of people diagnosed with HIV on antiretroviral therapy	Health Management Information System (HIV observational data base)
% of people diagnosed with curable STI cured	Health Management Information System
Accuracy of laboratory diagnosis of HIV and STIs	External Audit
Frequency of shortages in availability of essential drugs and commodities (number and % of sites reporting no stock out of drugs and supplies)	Annual report
Number of HIV infections occurring through use of blood products in medical procedures	Surveillance system
Number of needlestick injuries	Health Management Information System
Number of health care workers infected with HIV through occupational exposure	Surveillance system

PROCESS

Provision of comprehensive quality HIV clinical service in Dili	Participation in quality assurance system (e.g. Treat Asia Project)
Protocols/systems established for	Health Management Information System

provision of ARV treatment and monitoring of patients outside Dili	(HIV observational database)
Capacity available for treatment of opportunistic illnesses	Health Management Information System
Protocols developed for commencement of ARV therapy including drug regimens	Protocols distributed by MOH
Patient confidentiality protocols developed	Protocols distributed by MOH
Shared care protocols developed for patients co infected with TB	Protocols distributed by MOH
Protocols developed for management of pregnant women with HIV	Protocols distributed by MOH
HIV clinical services standing committee be established under NAC	NAC report
STI syndromic management available at all public health services	Health Management Information System
% of public health services complying with standard operating protocols for STI syndromic management	Quality Improvement System
STI syndromic management protocols revised and modified if necessary	Protocols distributed by MOH
% of MARGs receiving STI enhanced syndromic management as standard of care	Behavioral surveys; sentinel surveillance
Enhanced syndromic management protocols developed for MARGs	Protocols distributed by MOH
Regulatory framework established for private sector provision of laboratory services	NAC clinical standing committee report
Systems developed to enhance diagnosis of bacterial STIs and microbial susceptibility	NAC clinical standing committee report
Protocols and systems for the procurement and supply of drugs and other commodities be reviewed and modified if necessary	Review Report
Regulatory framework be established for private sector involvement in supply of drugs and other commodities	Review report
Number of blood donation and storage facilities increased	Health Management Information System
Universal infection control protocols developed	Protocols distributed by MOH
Post Exposure Prophylaxis for health care workers available through the national hospital	HIV observational database

4.2 Milestones

The table below identifies milestones to be achieved in 2006. Their achievement is dependent on funding being secured from sources other then the Global Fund to Fight AIDS, TB and Malaria. Significant funding from the Global Fund is not expected before late 2006.

ACTION	**Date**	**Funding**	**Lead Agency(s)** **Manager** Key partners
Education and Prevention			
National Youth HIV/AIDS Prevention Campaign		$450,000	**MOH** **UNICEF**
Training of peer facilitators	May		
District youth camps	July		
National campaign launch	August		
Life Skills Education		$400,000	**UNICEF ;MOE** MOH
School based program implemented	Ongoing		
Out of School youth program implemented	June		
Sex workers program implemented	September		
World AIDS Day General Population Campaign		$46,000	**NAC**
National media and local activities	December		
Most At Risk Groups targeted prevention program		$140,000	**FTH; CVTL** **FHI (till June 06)**
MSM Dili outreach program implemented	Ongoing		
MSM region based peer support projects commenced	September		
Sex Worker Dili outreach program implemented	Ongoing		
Sex Worker outreach projects commenced in border districts and Bacau	August		
Uniformed services education program implemented	Ongoing		
VCT			
VCT (pregnant women) district services		$41,000	**MOH ;**UNICEF WHO

Protocols adopted for provision of VCT to pregnant women	June		
One health care worker from each district trained in VCT provision for pregnant women	August		
Service established in each district	October		
District (MARGs) services		$26,000	**MOH** FTH; CVTL
Protocols adopted for provision of VCT for MARGs	June		
One health care worker from each district trained in VCT for MARGs	August		
Service established in each district	October		
Multi-sectoral			
Development of sector plans		$26,000	**NAC** UNDP
Military sector plan developed	March		
Police sector plan developed	June		
Education sector plan developed	June		
Antidiscrimination legislation		$21,000	**NAC** UNDP
Legislation drafted	August		
Legislation passed	November		
Policy Project		$55,000	**NAC;**UNDP
Review commences	June		
Policy review	November		
Region HIV Project Officers		48,800	**NAC;**UNTG
Tender selection process implemented	April		
Project Officers employed	May		
HIV Positive Development Project		$14,200	**NGO;**MOH
Tender selection process implemented	April		
Project commenced	May		
Clinical			
Provision of Anti retroviral treatment		$48,500 (+ donated drugs)	**MOH;** Brazil corporation**;** ASHM

			WHO
Establishment of Clinical standing Committee of NAC	April		
Development of treatment protocols	June		
Accredited training of doctor from each district	August		
Conference attendance for HIV prescribers	August		
Confidentiality guidelines adopted	June		
Training for nursing and auxiliary staff	September		
Shared care protocols with TB and maternal/child health services developed	December		
Region enhanced syndromic management provision for MARGs		$104,000	**MOH** WHO
Protocols developed	September		
Training of nursing and medical staff	November		
Service promotion	December		
STI counseling		$26,000	**MOH** WHO
Protocols developed	September		
Training of nursing and medical staff	November		
Service Promotion	December		
Planning and coordination			
National HIV/AIDS/STI strategic Plan			**NAC;**MOH
Strategy adopted	February		
National AIDS Commission		$64,600	**NAC;**MOH
Terms of Reference and executive membership announced	February		
Full membership announced	April		
Manager recruited	April		
First meeting	May		
Premises secured	May		
Other staff recruited	May		
National Monitoring and Evaluation Plan		$25,000	**MOH;**NAC
Draft	May		
Final Plan	June		

District Action plans		$60,000	**NAC;**MOH**;**UN
Draft	February		
District coordination committees	April		
1 year plans adopted	April		
National Strategy website		$5000	**NAC**
Established	May		
Strategic Planning			
National Population Behavior Survey		$97,000	**MOH;**NAC
Tender developed	June		
Tender process completed	August		
Survey completed	November		
MARGs behavioral surveys		$50,000	**MOH;**NAC**;**FTH CVTL; FHI
Tender developed	June		
Tender process completed	August		
Surveys completed	November		
HIV/STI routine surveillance		$6,500	**MOH;**WHO
Expand notification fields to include syndromic disease diagnosed, gender and age	May		
Sentinel surveillance system		$10,500	**MOH;**WHO
Identify sites for sentinel surveillance	June		
Develop protocols	July		
Training workshop	September		
Commence information collection	October		
HIV Treatment Observational data base		$20,000	**MOH;**ASHM**;**WHO
Assess feasibility of participation in Treat Asia	May		
Develop protocols	July		
Record information	Nov		